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Considerations in a Brief Therapy Model for Music Therapy

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Considerations in Brief Therapy Model for Music Therapy

By Justin Francis

A Master's Thesis Submitted to the Faculty of Montclair State University

In Partial Fulfillment of the Requirements For the Degree of Master of Arts, Music Therapy

August 2010

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CONSIDERATIONS IN A BRIEF THERAPY MODEL

FOR MUSIC THERAPY

A THESIS

Submitted in partial fulfillment of the requirements for the degree of Master’s in Music Therapy

By

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August 2010
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Abstract

The purpose of the study is to ascertain the extent to which music therapists are working in ways that utilize components of brief therapy. The goals are to gain insight into the following: 1) Are music therapists utilizing brief therapy? 2) What are music therapists' perception(s) of brief therapy work? A total of 108 Board-Certified Music Therapists participated in a three-part survey consisting of demographic information, clinical experience, and various perceptions pertaining to applications of brief music therapy. Survey Monkey administered the survey for one month via a linked email cover letter. Data from the survey was descriptively summarized. A Principal Components Analysis (PCA) revealed six components concerning the participants' perceptions of brief music therapy. The findings revealed that music therapists are indeed utilizing elements of brief therapy in short-term settings and value brief approaches given the trends and constraints in the field. Implications for future work in this area were considered.
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Literature Review

In recent years, brief therapy has gained greater respect and consideration among healthcare providers as a viable approach to meet insurance mandates and minimize hospital expenditures. Acute and sub-acute facilities have been embracing the "short-term hospitalization" model as a way to combat the rising cost of healthcare (Murphy, 1992; Shultis, 1999). Approaches in brief therapy were introduced, in part, to meet the demands set by third party payers, managed care, and hospital regulations (Fisch & Schlanger, 1999; Stern, 1993; Yalom & Leszcz, 2005).

Shultis (1999) argued that the current trend towards short-term care may impose dilemmas over the quality of care being provided by the healthcare system. As of yet there is little in terms of music therapy strategies to negotiate this clinical obstacle thus requiring us to "rethink" our approaches (Shultis; Thomas, 2007). It is critical in short-term settings to "design music therapy interventions that are appropriate, cost-efficient, and that result in patient satisfaction" (Cassity and Cassity, 2006, p. 200). The ability of music therapy to be spontaneous and flexible may form the backbone of treatment
strategy design used in short-term settings (Jacobowitz, 1992).

**Definition and Characteristics of Brief Therapy**

A universally accepted definition of brief therapy has not been developed. This phenomenon is probably due to the broad spectrum of theoretical methodologies and practice models in psychology and related disciplines. In response to the absence of a universal definition I drew from common elements seen in the literature to develop a working definition. For the purpose of this study, brief therapy is defined as an eclectic clinical approach (Budman & Gurman, 1988; Walter & Peller, 2000) that addresses specific needs and complaints (Fisch, Weakland, & Segal, 1982; Stadler, 1996) within a predetermined or clinically determined time-frame (Hudson-Allez, 1997; Miller, 1996). After a thorough review of the literature, I have identified five fundamental components that make brief therapy unique among other service delivery models: 1) it is characterized by the limitations of therapeutic time, 2) treatment goals often are reflective of the immediate condition(s) or needs presented by the client, 3) treatments are designed to be achievable within the given time-frame, 4) therapeutic time is either negotiated or predetermined, 5) it involves a
mutual contract, or agreement, between the client and therapist. Each of these five components will be examined in greater detail in the following section.

**Nature of Therapeutic Time**

The nature of time is at the philosophical center of brief therapy work. Miller (1996) claims that the agenda of managed care results in intentionally faster therapeutic processes. Budman and Gurman (1988) argued that the nature of time in brief therapy allows for goals to be accomplished at higher rates. These perspectives indicate that constraints placed on time creates a clear sense of urgency, and directs treatment priorities in therapy.

Inherent in the time constraints of brief therapy is the impact upon the nature of termination (McGuire & Smeltekop, 1994a; McGuire & Smeltekop, 1994b). Jacobowitz (1992) claims, short-term work is laden with intense time pressures and, hence, time-limitations pose a unique challenge on the part of the therapist especially in regards to termination. Jacobowitz writes, "The therapist walks a delicate line between addressing pertinent issues but not addressing issues that are too complex for short-term hospitalization" (p. 49). Thus, in brief therapy, the therapist must find a way to terminate each session while
leaving the door open for continuation, amidst the intrinsic pressures of time

**Goal Immediacy**

Time limitations in brief therapy make it difficult to address goals in large numbers or on a long-term basis effectively. Therefore, acute-care work emphasizes the immediate needs of a client. Hoyt (2001) suggests that brief therapy is effective at reducing symptomatology rather than the entire make-up of the condition; whereas other practitioners have focused primarily on improving quality of life within the short-term (e.g., Anchin, 2003; Ayson, 2008). According to Cepeda and Devenport (2006), it may be prudent to tailor the treatment to a specific need that focuses on the here-and-now as well as on the client’s strengths.

When restricted by time, it is critical in therapeutic work to select appropriate goals. Stern (1993) suggests that, due to the nature of time within the therapeutic environment, it is important to keep the primary focus on the presenting problem, complaint, and/or issue. Additionally, goals must be realistic, achievable (Anchin, 2003; Jacobowitz, 1992), specific, and meaningful for the well-being of the client (Cepeda & Devenport, 2006). Some
common issues seen in adult sub-acute in-patient psychiatric settings include: Anxiety, sleep disturbances, lack of reality orientation, communication difficulties, and problem-solving deficits (Shultis, 1999). In the pediatric setting, goals often focus on communication, socialization, expression, relaxation, recovery (Jacobowitz, 1992), normalization, reinforcement of learning, and support for parents (Ayson, 2008). In addition, the therapeutic goal direction in short-term pediatric care can also focus on the clients' experiences of hospitalization (Jacobowitz, 1992).

Achievability

In brief therapy, various components of therapy must be achievable within the designated, limited time frame allotted. These components include assessment, intervention, and goals.

Due to the time limitations of brief therapy, thorough assessments might not be appropriate or achievable (Jacobowitz, 1992). Thus, under these conditions, it is advised to examine patient-related materials prior to the first meeting. Histories, referrals, care plans, physician's notes, nursing charts are all key areas for determining client needs (Ingram, 2003). Assessments in
brief therapy should be conducted rapidly (Anchin, 2003) and with flexibility (Jacobowitz, 1992).

Hudson-Allez (1997) identified the following criteria for assessment in short-term therapy work which may be applicable to music therapy work: 1) determine client willingness to work with the clinician, 2) identify appropriate approaches that fit client needs, and 3) assess whether presented issue(s) are realistically achievable given the limitations of time. Those criteria when adapted to music therapy may focus on determining: 1) willingness to participate and work with the clinician, 2) musical functioning, preferences, and strategies, and 3) whether client needs can be addressed in brief music therapy.

Interventions used in brief therapy models should be designed to be meaningful and achievable, according to the client’s condition. The degree of structure (versus freedom) involved in the intervention should depend heavily upon the client’s levels of emotional and developmental functioning (Murphy, 1992). In some clinical situations, a therapist might only see a patient or group once; thus designing appropriate interventions can be a major clinical challenge even for the most experienced clinician.

Suggested treatments in acute care focus on the here-and-
now orientation and any immediate issues presented by the clients (Murphy, 1992; Shultis, 1999). Nevertheless, clinicians should provide a safe environment that promotes self-expression, psychosocial well-being, and general health (Murphy, 1992).

Finally, goals must be achievable within the designated time frame. This is important not only for the client’s welfare but also for the integrity of the therapeutic relationship. Therefore, goals must be realistic, specific, small in scope, qualitatively positive and both meaningful and important to the client (Cepeda & Devenport, 2006).

**Therapeutic Time Frame**

There are two general approaches in brief therapy based upon the nature of the clinical time frame. Descriptions of each now follow.

The first is the time-limited therapy (TLT) approach. The TLT approach has a predetermined number of sessions. For example, Weiss & Marmar (1993) developed a 12-session, dynamic, psychotherapeutic model for the treatment of post-traumatic disorder and pathological grief. TLT is most
notably associated with managed care and acute care settings where there is a predetermined time frame.

The second is referred to as clinically determined treatment (CDT), in which the number of sessions are determined collaboratively by client and therapist (Miller, 1996). Molyneux (2001) provides an example of this in her description of work with a nine year old girl who had anxiety and eating deficiencies. The original treatment time frame was scheduled for only six weeks. However, the client's treatment was extended by the therapist for an additional four weeks because of the positive progress in self-esteem and eating. Following the extension, the therapist felt the child made significant progress and determined it was appropriate to terminate "on a positive note" (Molyneux, 2001, p. 55).

**Mutual Contract**

Brief therapy requires that the therapist and the patient agree upon and accept a specific set of goals based upon what can realistically be accomplished within the predetermined time frame (Bolter, Levernson & Alvarez, 1990). The mutual contract thus addresses 1) pragmatic and realistic views on treatment (Bolter et al.), 2) client
expectations (Reiter, 2007), and 3) termination (Pinkerton & Rockwell, 1990).

In a pragmatic view, the contract is based on a mutual understanding of client needs, goal priorities, and treatment. Budman and Gurman (1983) suggested that both the therapist and client need to have a realistic understanding of what brief therapy can accomplish. In this sense, brief therapy is not viewed as a cure for illness but rather a temporary aid in the immediate short-term (Bolter et al., 1990).

Another component of the contract in brief therapy is an acknowledgement of expectation for change to occur, whether on the order of a small leap or a large transformation (Reiter, 2007). As possible (in part depending upon the population served), the client needs to be aware of such expectations, as well as the limitations of the therapy. Reiter (2007) argues that part of the therapist's task is to help define the context of therapy, and to help create expectations of problems and solutions.

Because termination is at the center of brief therapy work (Jacobowitz, 1992; Pinkerton & Rockwell, 1990), a discussion of termination must occur as part of the therapeutic contract. In some clinical situations, the
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therapist must terminate (in a sense) at the end of every session with the prospect of allowing for future sessions to occur (Jacobowitz, 1992). Jacobowitz offers the following way of presenting the idea of termination to clients, within the context of a mutual contract:

If your hospitalization ends, then we are saying goodbye, but if you do not leave the hospital, I look forward to our continued work together, I hope that you will recover and go home, but I will still be happy to see you again (49).

Additional components addressed in the mutual contract include: 1) the termination process, 2) post-termination evaluation, and 2) post-treatment referrals.

One of the major challenges faced in the termination process is preparing the client to continue "...the process of therapeutic change after formal therapy ceases" (McGuire & Smeltekop, 1994a, p. 23). McGuire and Smeltekop suggest that ideally termination is based on the co-operative knowledge that the client has learned new skills and grown in confidence to cope with future stressors. Furthermore, they suggest that termination is not just the evaluation of change made thus far, but rather, a realization of the future. Ideally following termination a client should have
gained a certain level of new insights, strengths, mastered skills, and is ready for life's challenges (McGuire & Smeltekop).

During the termination process, the therapist must judge if the client has met his/her treatment goals (Ingram, 2003). The termination approach taken is at the discretion of the therapist based on the client's emotional and developmental level of functioning (McGuire & Smeltekop, 1994a; McGuire & Smeltekop, 1994b). Ideally, the therapist should provide appropriate closure.

Post-termination evaluations are a re-examination of effects of earlier treatment following discharge. Following up with clients can provide valid emotional support and communicates to the client that the therapist has not forgotten her or him (Fisch & Schlanger, 1999). Others have disagreed with this, and believe that post-termination follow-ups may undermine the client's confidence in her or his progress, and are thus not recommended (McGuire & Smeltekop, 1994b).

Post-termination follow-up evaluations are a common component in acute-care settings. For example, a day or two following a surgical procedure the surgeon's office will check in with a client to see how she or he is feeling. In
addition, many medical procedures require the client to come back to the office for a follow-up visit. Post-termination follow-up evaluations have not been written about in the music therapy literature.

As part of the mutual contract, the continuum of care in short-term settings is based on referrals. Brief therapy provides a certain level of care and, often, clients are referred for continued care if it is deemed necessary. There is no relevant literature pertaining to a referral system in music therapy. However, there are several reasons for a music therapist to refer a client upon the completion of short-term therapy: 1) client did not meet goal(s) set and/or the therapist is unable to continue treatment, 2) in the process of therapy deeper issues immersed that could not be realistically addressed within the treatment timeframe (McGuire & Smeltekop, 1994a), and 3) client met goals but shown interest in being referred to another creative-arts therapists, community music group, or for private music lesions.

In addition, the various purposes served by the contract in brief therapy described above it also aids in the establishment of the client-therapist relationship and
in the development of trust within the therapeutic process (Ingram, 2003; Weiss & Marmer, 1993).

**Brief Therapy Models in Music Therapy**

Literature on brief music therapy is limited and mainly concentrated within psychotherapeutic practice. Pearson (2005) suggests that as the music therapy field expands, it will need to develop different models and approaches to be effective in short-term clinical settings. The results of a Delphi Poll study determined that brief therapy and short-term work are likely to increase in music therapy psychiatric settings (Cassity, 2007). Moreover, Silverman (2009) suggests that even single-session approaches can be relevant in short-term music therapy work. Therefore, it is important for music therapists to continue examining the potential for brief therapy applications, perhaps more intensively than in the past.

There have been a handful of clinical papers describing the use of music therapy in short-term contexts. It is interesting to note that the majority of these models have focused on specific populations; however, Cassity and Cassity (2006) have developed a model that can be used across populations. The BASIC I.D. consists of clinical guidelines for use in brief therapy. BASIC I.D. is an
acronym for behavior, affect, sensory, imagery, cognitive, interpersonal, and drugs. It provides a format for conducting assessments and establishing a treatment plan for use in brief therapy settings. The principle focus of the BASIC I.D. is to stabilize the patient, and to focus on a specific problem or need. The authors have developed a diagnostic coding system that consists of 200 perceived conditions and 354 outlined music therapy interventions. Using these interventions, music therapists can easily conduct numerous interventions within a single session.

Beyond Cassity and Cassity’s model, others have focused upon specific populations, including those receiving services in psychiatric, medical, developmental, and family settings. These models will now be described here.

**Psychiatric Settings**

Boyle (2008) has developed a brief therapy model for use in the psychiatric setting. Her model consists of a 10-session goal-directed approach for psychiatric work based on the treatment of targeted issues or complaints. Though it is designed for use in psychiatric settings, Boyle believes it could be used effectively across all healthcare modalities. In addition, the model is centered
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on a case formulation plan that requires the client and therapist to agree upon treatment prior to third party payment and/or reimbursement. Case formulation includes: 1) client identification information, 2) presenting problem, 3) client history, 4) diagnostic information, 5) treatment plan, and 6) report. Overall, Boyle's plan appears to be a well-developed model that calls for an extensive evaluation for its effectiveness.

Slоторфф (1994) has developed a single-session, structured drumming technique for teaching assertiveness and anger management to adult and adolescent survivors of trauma in acute psychiatry. The drumming technique involves the use of specific vocal commands (e.g., "Yes," "No," and "Stop") to help clients feel a sense of empowerment through awareness of their feelings. These verbal commands allow clients to have directional control during the drumming interaction with the therapist. In implementing this model, Slоторфф noticed that clients responded positively to the single-session. Findings indicated that clients were more engaged verbally, more assertive, and felt more empowered directly following the drumming experience.
Leite (2003) has developed a structured group music therapy model for adults in acute psychiatric settings, based on psychodynamic principles. The model alternates between improvisational approaches and verbal discussion. The primary focus of this approach is to build up interpersonal defenses, establish personal boundaries, and gain self-control in a ritualized setting. There are three major goals in this model: 1) help patients survive their hospital experience, 2) build-up personal tolerances, and 3) delineate interpersonal boundaries.

The Integrative Creative Arts Therapy (ICAT) model was designed and instituted to address primary complaints in short-term mental health (Goldstein-Roca & Crisafulli, 1994). The ICAT model centers on a solution-focused approach aimed at determining optimal solutions to presenting problems. The model integrates poetry, music, and art therapies in a structured group setting. A verbal interview assesses the client's immediate needs, motivations, and drives, as well as past positive encounters, and hopes for the future (Goldstein-Roca & Crisafulli). In this model, there are no predetermined numbers of sessions, and each subsequent session incorporates themes and elements from previous experiences.
Moreover, the music and art in these sessions helps to reinforce the client’s feelings and to reinforce the idea of appositive change.

Molyneus (2001) has developed a short-term model for use with children and adolescents attending a mental health day program. In this model, both group and individual sessions are scheduled for one hour, either within a predetermined time frame, or within a time frame clinically determined by the therapist. Free improvisation is used to help the children explore communication, interaction, and ways of expressing themselves. Through analysis of several case vignettes in which this method was applied, Molyneux concluded that musical relationships could be established within short-term mental health treatment. For her, short-term therapy is a catalyst, as opposed to a “vehicle,” for change. Molyneux focused most of her attention on termination issues concerned in brief therapy work, as she describes in the following account:

I was acutely aware, when assessing client for individual music therapy, of the question, what can be achieved in the time scale available? I hope to give the ending to the therapeutic relationship the importance it required; despite the external factors...
have found it useful at times, to be placed in a position where time is limited. I feel that this has enabled me to trust more in the process involved in the therapy as the ending is firmly in sight and planned (p. 30).

Montello (2000) has developed an instructional, twelve-week short-term group wellness seminar entitled *Music Therapy for Musicians*, designed to address the management and prevention of performance stress and anxiety. The seminar combines cognitive-behavioral approaches with mind-body awareness strategies in an improvisation-based framework. Improvisation is utilized to help musician's foster spontaneity and gain self-confidence.

**Medical Settings**

Music making acts as a crisis intervention that allows individual children to connect through sound to themselves, to the therapist, and to their environment, all in an unfamiliar setting such as a hospital (Jacobowitz, 1992). General goals include making contact, utilizing opportunities to express and communicate needs, relaxing and having fun, socializing with others, and developing a sense of mastery and success concerning the experience of
being hospitalized. Goals are based on the perceived length of stay, and must have realistic expectations. When considering the intervention, the music therapist must have a general idea while also having the ability to be spontaneous within the music space, as needed.

Jacobowitz (1992) has developed an approach to music therapy treatment in acute medical settings that includes guidelines for organizing treatment, conducting assessments, developing appropriate goals/objectives, and providing closure and termination. Jacobowitz believes that short-term music therapy can meet many needs of hospitalized children.

Pearson (2005) implemented a pilot program entitled "brief creative therapy," which focuses on single-session music groups in acute medical settings. The music group, which she refers to as Music & Memories, was established in order to improve quality of life by treating anxiety, depression, loneliness, and isolation experienced by patients in an acute care setting. In the setting where it was developed, the Music & Memories group involved both the patients and their families in a structured-yet-flexible, non-threatening environment. The therapist utilized a "theme bank" (containing a set of pre-selected songs), and
took a flexible interventional approach during the musical activities. A feedback form was designed to measure patient responses to the group. Pearson concluded that the group was a success and effectively treated the whole person, rather than just the symptoms.

**Developmental Settings**

Aigen (1998), in researching Nordoff-Robins clinical work between 1961 and 1962, found that it was predominantly short-term. According to Aigen, an in-depth study of case accounts from this early period suggests that Creative Music Therapy may not have been intended as either a long-term or supportive approach. Aigen writes:

> This seems to express Clive's view that the work is surgical, oriented to a fast, directed, potent change in the child rather than as a long-term, open-ended, supportive approach. And that perhaps this aspect of their work was not related to the tenuousness of their personal lives and the lack of extended commitments from institutions, but more to an active belief which was independent of their personal circumstances (p. 243).
Family Settings

Oldfield (1993, 1999) describes the use of short-term music therapy interventions when working with families. Her clinical work addressed issues related to self-esteem and the mother-child relationship, all within a predetermined number of sessions. Interventions focused on establishing communication and interactive play, in order to identify positive relationship attributes between the mother and child.

Oldfield and Bunce (2001) have developed an approach for utilizing short-term group music therapy with mothers and their young children. The primary focus of their work related to the development of the parent-child relationship. Their work utilized both verbal and non-verbal interventions, addressing positive aspects of parenting. All sessions were taped and reviewed by the therapist and parent to encourage parent-child bonding.

Research on Brief Approaches in Music Therapy

In many instances, brief interventions in music therapy are practiced unintentionally; or rather, occur naturally (Stadter, 1996). As the result of shorter hospitalization, clients ultimately receive fewer sessions
for addressing their clinical needs (Silverman, 2008). Thus, there is greater pressure on music therapists to demonstrate effectiveness, within shorter time frames, in order to receive and maintain funding. Like many healthcare professions, music therapy is increasingly criticized for a lack of quantitative research (Silverman & Marcionetti, 2004) and evidence-based treatments (Aldridge, 2003; Silverman, 2009; Vink & Bruinsma, 2003). Silverman (2009) argues that conducting research in short-term treatment settings imposes many challenges and involves many variables that increase the occurrence of unforeseen outcomes. He suggested that manualized single-session designs could be utilized effectively in research to control for subject attrition and unpredictable variables. Furthermore, Silverman and Marcionetti (2004) suggest, manualized single-session designs can accurately measure the immediate, short-term effects of music therapy interventions.

**Single-Session Research**

Due to the general nature of acute care settings, basic comforts and compassion are regularly overlooked (Almerud & Peterssson, 2003). Acute care can be very intimidating environments for newly admitted clients
Considerations in Brief Therapy (Pearson, 2005). Music therapy, like other related professions, is currently faced with demonstrating treatment efficiency in these settings to support healthcare consumer needs. Studies have shown evidence that single-session research designs can be effective for addressing these issues (Silverman, 2008). Single-session studies can support the efficiency of music therapy in acute settings, as long-term effects would be difficult to control for (Silverman & Marcionetti, 2004). The following section will describe single-session research designs in both acute medical and psychiatric settings.

Medical Settings. Almerud and Petersson (2003) examined the effects of short-term music therapy on relaxation with clients on temporary mechanical ventilation in the intensive care unit (ICU). Subjects in the experimental group received pre-selected music (classical genre) twice, for a duration of thirty-minutes each. Physiological measurement on heart rate, blood pressure, respiration, and oxygen saturation were taken in five-minute intervals during the receptive intervention. A thirty-minute group interview occurred post-ventilation. Physiologic data indicated a reduction in all three parameters, yet heart rate rose significantly following
treatment. The interview revealed no significant information, yet the study as a whole revealed that short-term "dosages" of music therapy can help reduce certain physiologic symptoms in clients in the ICU.

**Psychiatric Settings.** Silverman and Marcionetti (2004) compared the immediate benefits of five different single-session music therapy interventions on common deficits seen in severely mental ill clients being treated in acute psychiatric settings. The five interventions utilized in this study were group drumming, music games, lyric analysis, song writing, and music listening. Participants were randomly assigned to one of five conditions. No control was included and group processing took place following each session. Pre- and Post-test surveys were used to rate self-esteem, expression, knowledge of healthy coping skills, mood, anger management, symptom knowledge, hospital experience, and music therapy experience (Silverman & Marcionetti, 2004). Results indicated that all interventions had a positive impact on subjects in a single-session.

Silverman (2009) compared the effects of a single psychoeducational music therapy session, versus a non-music equivalent, on verbalization and perceptions with clients
in acute psychiatry. Subjects in the experimental group received a manualized song listening and lyric analysis experience focusing on relapse prevention. Satisfaction, psychoeducational knowledge, and verbalization were all measured. Findings revealed that the single-session, structured approach helped subjects increase levels of verbalization and personal insights. Subjects rated music therapy as helpful in their recovery. These findings suggest that single-session, psychoeducational approaches can be effective tools for clients in acute psychiatry.

Jones (2005) utilized a single-session approach for comparing the effectiveness of songwriting and lyric analysis on evoking emotional change in clients with chemical dependency. Twenty-six participants were divided evenly into song writing group and lyric analysis groups. Both group experiences were equally effective in evoking willingness to change, and in reducing self-defeating emotions (Jones, 2005). Additionally, about three quarters of the participants viewed the single-session to be helpful in their recovery.
Purpose of the Present Study

There is a trend toward short-term work in healthcare. As a result, more music therapists are working under the time constraints of the acute care setting. While the literature presents a handful of studies examining music therapy in short term settings, the actual prevalence and perceptions of this work is unknown. Thus, the purpose of the present study is to ascertain the extent to which music therapists are working in ways that utilize components of brief therapy. The goals are to gain insight into the following: 1) Are music therapists utilizing brief therapy? 2) What are music therapists’ perception(s) of brief therapy work? Knowledge gained through this study may help contribute to the generation of a brief therapy model in music therapy.

Method

Participants

Participants were 99 women and 8 men, ranging in age from 22 to approximately 60+ years. Potential participants were selected from a database of board-certified music therapists provided by the Certification Board for Music Therapists, Inc (CBMT). Only those certificants who have given CBMT permission to share their contact information
with third parties were eligible to participate in this study. This resulted in a list of 1000 music therapists invited to participate in this study.

Invitations were sent via email. Included in the email cover letter (refer to Appendix A) was a request of participants to read five statements regarding their clinical work, derived from the working definition of brief therapy presented in this study. Participants were then instructed to assess whether their clinical work reflected three or more of the statements. This measure was designed to rule out prospective participants whose work did not qualify as brief therapy. Participants who responded affirmatively to the inclusion criterion query were invited to proceed to the survey via a website link.

Survey

Participants took a survey designed by the researcher, addressing, among other information, the five components primary aspects of brief therapy (refer to Appendix B). The survey was administered online through Survey Monkey for little over one month (between April 28th - June 2nd). The survey consisted of the following sections: 1) Questions pertaining to demographic features of participants, 2) yes/no questions regarding brief therapy work, and 3)
assorted, five-point Likert-Scale statements examining individual perceptions of brief therapy.

Section one of the survey asked thirteen demographic questions. These concerned gender, age, years of experience as a music therapist, region employed, education, additional training, current employment, level of care provided, employment title, services, treatment priorities, and commonly encountered clinical need(s).

Section two of the survey asked eleven yes/no questions regarding clinical work pertaining to brief therapy, followed by a few open-ended statements. Section two was intended to address Research Question One, "Are music therapists utilizing brief therapy?". Questions addressed relevant areas related to the number of sessions provided, single sessions, client collaboration in treatment development, clinical expectations, termination, and post-termination evaluations.

Section three of the survey asked participants to rate thirty-four statements about brief music therapy on a five-point rating scale. This section was intended to address Research Question Two, "What are music therapists perceptions of brief therapy?". Statements focused on relevant areas related to time-limitations, brief
assessments, termination, and a brief music therapy model. The statements in section three were presented in random for each participant.

**Data Analysis**

Individual sets of data collected through Survey Monkey were converted into aggregate form via SPSS. The aggregate data were then analyzed using descriptive statistics, in order to summarize the general responses of participants in the first two sections of the survey. Data from the third section was plotted using a principle components analysis (PCA) to explore meaningful inter-correlations among the variables (Likert ratings of the statements).

**Ethical Issues**

Because there are relatively few music therapists within the music therapy profession as a whole, there was a small risk of identification based upon the uniqueness of any given single data set. These risks of participant identification were very minimal, however, and identification would not have been particularly detrimental to participants, given the relatively innocuous content of the data. Yet, the potential benefits for gaining new
insight in the role of music therapy in the clinical context of brief therapy work were significant. The survey asked only for non-personal demographic information, questions related to brief therapy, and perceptions of brief therapy; thus, anonymity was well preserved, even within the relatively small population pool. Survey Monkey is an encrypted data collection tool, and does not disclose personal details. Data were viewed via statistical spreadsheet, and only the researcher and researcher’s advisor had access to the data. The survey was conducted on a strictly voluntary basis—participants had the right to pause, to skip any questions, and/or to withdraw from the study all together (without fear of repercussions), at any point during the survey administration. The survey and cover letter (which included a consent statement) were approved by the Montclair State University Institutional Review Board (refer to Appendix C).
Results

Background Information

The following section outlines responses of participants to thirteen, demographically specific questions.

Gender. Table 1.1 shows gender of those music therapists who responded to the survey. The majority of participants were female.

Table 1.1 Gender

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>7.5%</td>
<td>8</td>
</tr>
<tr>
<td>Female</td>
<td>92.5%</td>
<td>99</td>
</tr>
</tbody>
</table>

answered question 107
skipped question 1

Age. Table 1.2 shows age ranges of those music therapists who responded to the survey. Among the participants who answered this question, there is a range of ages (between 22 and 60+ years).
Table 1.2 Age

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 22</td>
<td>0.0%</td>
<td>0</td>
</tr>
<tr>
<td>22-29</td>
<td>41.1%</td>
<td>44</td>
</tr>
<tr>
<td>30-39</td>
<td>40.2%</td>
<td>43</td>
</tr>
<tr>
<td>40-49</td>
<td>4.7%</td>
<td>5</td>
</tr>
<tr>
<td>50-59</td>
<td>10.3%</td>
<td>11</td>
</tr>
<tr>
<td>60+</td>
<td>3.7%</td>
<td>4</td>
</tr>
</tbody>
</table>

answered question 107
skipped question 1

Years of Experience as a Music Therapist. Table 1.3 shows the number of years of experience of those music therapists who responded to the survey. Among the participants who answered this question, there was a range of work experience as a music therapist (from less than a year to 20 years). 43.9% of participants have two to five years of work experience as a music therapist.

Table 1.3 Years of Experience as a Music Therapist

<table>
<thead>
<tr>
<th>Location</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤ 1 yr</td>
<td>12.1%</td>
<td>13</td>
</tr>
<tr>
<td>2-5 yrs</td>
<td>43.9%</td>
<td>47</td>
</tr>
<tr>
<td>6-10 yrs</td>
<td>24.3%</td>
<td>26</td>
</tr>
<tr>
<td>11-15 yrs</td>
<td>9.3%</td>
<td>10</td>
</tr>
<tr>
<td>16-20 yrs</td>
<td>2.8%</td>
<td>3</td>
</tr>
<tr>
<td>20+</td>
<td>7.5%</td>
<td>8</td>
</tr>
</tbody>
</table>

answered question 107
skipped question 1

Region in Which Employed. Figure 1 shows the different regions of employment of those music therapists who
responded to the survey. The majority of participants (21.5%) are employed in the Mid-Atlantic region.

Figure 1 Region in which Employed

Highest Degree Earned. Table 1.4 shows the higher education background of those music therapists who responded to the survey. The majority of participants (64) who responded to this question held bachelor’s degrees.

Table 1.4 Highest Degree Earned

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bachelors</td>
<td>61.0%</td>
<td>64</td>
</tr>
<tr>
<td>Masters</td>
<td>39.0%</td>
<td>41</td>
</tr>
<tr>
<td>Doctorate</td>
<td>0.0%</td>
<td>0</td>
</tr>
</tbody>
</table>

answered question 105
skipped question 3

Additional Training Designations Held. Table 1.5 shows additional music therapy certifications held by those music therapists who responded to the survey. The majority of
participants who responded to this question held the Neurology Music Therapy (NMT) credential. A total of fourteen participants held additional credentials; some indicated having more than one.

Table 1.5 Additional Training Designations Held

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>FAMI</td>
<td>9.5%</td>
<td>2</td>
</tr>
<tr>
<td>AMT</td>
<td>0.0%</td>
<td>0</td>
</tr>
<tr>
<td>NRMT</td>
<td>9.5%</td>
<td>2</td>
</tr>
<tr>
<td>NICU-MT</td>
<td>19.0%</td>
<td>4</td>
</tr>
<tr>
<td>HPMT</td>
<td>14.3%</td>
<td>3</td>
</tr>
<tr>
<td>NMT</td>
<td>61.9%</td>
<td>13</td>
</tr>
</tbody>
</table>

answered question 21
skipped question 87

Type of Facility Currently Employed. Table 1.6 revealed the different settings in which participants were currently employed as of this survey. The settings most reported were “other,” (32) followed by private practice (26) followed by psychiatric care setting (24). Of those who selected “other,” hospice settings (12) were the most specified.
Table 1.6 Type of Facility Currently Employed

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric Care Center</td>
<td>22.4%</td>
<td>24</td>
</tr>
<tr>
<td>Physical Rehabilitation Center</td>
<td>1.9%</td>
<td>2</td>
</tr>
<tr>
<td>General Medical Care Center</td>
<td>3.7%</td>
<td>4</td>
</tr>
<tr>
<td>Drug/Alcohol Rehabilitation Center</td>
<td>1.9%</td>
<td>2</td>
</tr>
<tr>
<td>Cancer Center</td>
<td>0.9%</td>
<td>1</td>
</tr>
<tr>
<td>Pediatric Care Center</td>
<td>3.7%</td>
<td>4</td>
</tr>
<tr>
<td>Private Practice</td>
<td>24.3%</td>
<td>26</td>
</tr>
<tr>
<td>School/Developmental Center</td>
<td>10.3%</td>
<td>11</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>30.8%</td>
<td>33</td>
</tr>
</tbody>
</table>

answered question 107
skipped question 1

For those who selected "other," settings included:

- Adult Bone Marrow Treatment Outpatient Clinic
- Hospice (hospice & Bereavement)
- Hospital System
- Residential Treatment Center
- Forensic Psychiatric Setting
- Nursing Home
- Assisted Living
- Medicare Wavier Program
- Community Music School
- Adult Day Support (Developmental Disabilities)
- Speech-Language Summer Camp
- Long-Term Care Center
- Contractor for Private Day School
Considerations in Brief Therapy 44

- Acute inpatient Psychiatric Facility
- Independent Contractor for private educational service
- Nursing & Rehabilitation Center
- Psychiatric Hospital for Offenders

Years Employed at Current Job. Table 1.7 shows the number of years participants have been employed at their current facilities. Among the answers to this question, there was a range of length of employment at current facility (from less than a year to 20 years). 45.8% of those who responded to this question had been employed at their current facility from two to five years.

Table 1.7 Years Employed at Current Job

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤ 1 yr</td>
<td>29.9%</td>
<td>32</td>
</tr>
<tr>
<td>2-5 yrs</td>
<td>45.8%</td>
<td>49</td>
</tr>
<tr>
<td>6-10 yrs</td>
<td>15.0%</td>
<td>16</td>
</tr>
<tr>
<td>11-15 yrs</td>
<td>2.8%</td>
<td>3</td>
</tr>
<tr>
<td>16-20 yrs</td>
<td>1.9%</td>
<td>2</td>
</tr>
<tr>
<td>20+</td>
<td>4.7%</td>
<td>5</td>
</tr>
</tbody>
</table>

answered question 107
skipped question 1

Lengths of Care. Table 1.8 shows the typically lengths of care given to clients based on the responses received by the participants. The length of care most frequently reported was greater than three months of care (60)
followed by greater than one week but less than or equal to three months of care (36).

Table 1.8 Lengths of Care

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than or equal to one week of care</td>
<td>10.3%</td>
<td>11</td>
</tr>
<tr>
<td>Greater than one week but less than or equal to three months of care</td>
<td>33.6%</td>
<td>36</td>
</tr>
<tr>
<td>Greater than three months of care</td>
<td>56.1%</td>
<td>60</td>
</tr>
</tbody>
</table>

Employment Title. The following outlines the various employment job titles of the participants. The employment titles most commonly reported was music therapist (67), followed by rehabilitation therapists (8), activity therapist (3), creative arts therapist (2), contract music therapist (2), and neurological music therapist (2). Other employment titles included the following:

- Artist in Residence Providing Music Therapy
- Marriage and Family Therapy Intern
- Outpatient Therapist
- Para Professional
- Therapeutic Recreational Therapist
- Music Therapist/Activity Director
• Music Therapy Director
• Music Therapist and Internship Director
• Creative Arts Coordinator
• Research Assistant, Music Therapist
• Registered Music Therapist III
• Clinical Director-Owner
• Director
• Music Therapy Program Manager
• Music Educator and Music Therapist
• Allied Clinical Therapist
• Owner-Music Therapist
• Music Therapist and Music Instructor
• Creative and Expressive Arts Therapist
• Program Coordinator-Employment Program (not music therapy related)
• Music Therapist and Behavioral Consultant
• Intensive Out-Patient Therapist

Types of Sessions Provided. Figure 2 shows the different types of sessions provided by those music therapists who responded to the survey. The majority of participants (61) indicated they provide both group and individual sessions at their facility.
Areas of Treatment Importance. Figure 3 shows how participant rated broad treatment needs, in order of clinical significances (Interpersonal/Socialization; Affective/Behavioral; Sensory/Imagery; Cognitive/Neurological; Speech/Language; Fine/Gross Motor) from 6 being most important and 1 being least important. Of the 106 music therapists who responded to this question, the most common, most important area reported was interpersonal/socialization (48); the most common, least important area was fine/gross motor (45).
Figure 3 Areas of Treatment Importance

Areas of Treatment Importance

- Ranking
- Response Count
- %

Incidence of Client Need(s) Encountered. Figure 4 shows the most commonly encountered client need(s) indicated by those music therapists who responded to this survey. 81 participants identified "expression" as the most frequently encountered client need, followed by "coping" (75), and "anxiety" (74). The least frequently encountered need identified was the client "hospital experience" (18).
Figure 4 Incidence of client need(s) encountered

Common Client Need(s) Encountered

<table>
<thead>
<tr>
<th>Need</th>
<th>Percentage</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comfort/Palliative</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leisure-time Skills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family/Friends</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coping</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problem Solving</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychosocial</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Experience</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recovery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relaxation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reality Orientation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sleep Disturbances</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>81</td>
<td></td>
</tr>
</tbody>
</table>

Yes/No Statements

The following tables will illustrate participant's responses to the yes/no statements, based upon how the questions were presented in the survey.

Limited number of Sessions. Table 2.1 shows that seventy-one participants stated that they are not limited to a specific number of sessions they offer to their clients. Common responses among those participants who
answered "yes" included: Single session (6), one to two sessions (5), two sessions (2), and 1-3 sessions (2).

Table 2.1 Limited Number of Sessions

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>33.0%</td>
<td>35</td>
</tr>
<tr>
<td>NO</td>
<td>67.0%</td>
<td>71</td>
</tr>
</tbody>
</table>

If YES, what is the typical number of sessions given?

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Clinically determining the number of sessions. Table 2.2 shows that of those who responded to this question, 68 indicated that they do not clinically determine the number of sessions given per client. Common responses from those participants that indicated "yes" included: Once per week (5), 2 sessions (4), once per month (2), and one to two sessions (2). One participant wrote, "Client and I discuss it together."

Table 2.2 Clinically Determining the Number of Sessions

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>35.8%</td>
<td>38</td>
</tr>
<tr>
<td>NO</td>
<td>64.2%</td>
<td>68</td>
</tr>
</tbody>
</table>

If YES, what is the typical number of sessions given?

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

answered question 106
skipped question 2
Single session. Table 2.3 shows that of those who responded to the question, 65 indicated that they do work with clients in a single session basis.

Table 2.3 Single Session

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>60.7%</td>
<td>65</td>
</tr>
<tr>
<td>NO</td>
<td>39.3%</td>
<td>42</td>
</tr>
</tbody>
</table>

answered question 107
skipped question 1

Client Collaboration. Table 2.4 shows that seventy-one participants (roughly 2/3%) indicated that they collaborate with clients in the development of the client’s treatment.

Table 2.4 Client Collaboration

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>66.4%</td>
<td>71</td>
</tr>
<tr>
<td>NO</td>
<td>33.6%</td>
<td>36</td>
</tr>
</tbody>
</table>

answered question 107
skipped question 1

Clinical expectations. Table 2.5 shows that seventy-four participants indicated that they do have a discussion of clinical expectations with their clients.
Table 2.5 Clinical Expectations

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>69.2%</td>
<td>74</td>
</tr>
<tr>
<td>NO</td>
<td>30.8%</td>
<td>33</td>
</tr>
</tbody>
</table>

answered question 107  
skipped question 1

Termination. Table 2.6 shows that sixty-three participants indicated that they do discuss terminations with their clients in short-term therapy.

Table 2.6 Termination

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>58.9%</td>
<td>63</td>
</tr>
<tr>
<td>NO</td>
<td>41.1%</td>
<td>44</td>
</tr>
</tbody>
</table>

answered question 107  
skipped question 1

Termination during the first session. Table 2.7 shows that the majority of participants (60) indicated that they do not discuss issues of termination with clients during the first session.

Table 2.7 Termination During First Session

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>21.1%</td>
<td>16</td>
</tr>
<tr>
<td>NO</td>
<td>78.9%</td>
<td>60</td>
</tr>
</tbody>
</table>

answered question 76  
skipped question 32
Those participants (68) who did not indicate that they discuss termination with their clients on the first session had the option to describe, in their own words, the termination process they use. The researcher chose not to directly label each individual response but rather to identify common reasons for termination in short-term settings. The most identified reason for termination was appending/immediate discharge (11), followed by end of life (9), every session viewed as potential for termination (4), and education settings (4). Some who responded to this question indicated time frames in which they provide closure. The most commonly identified time frame for closure was within the last two sessions (7), following by one month of closure. One participant offers 12 sessions and provides closure on the eleventh or twelfth session.

Referrals. Table 2.8 shows that seventy-four participants indicated that they do not offer referrals to their clients following termination.

Table 2.8 Referrals

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>29.5%</td>
<td>31</td>
</tr>
<tr>
<td>NO</td>
<td>70.5%</td>
<td>74</td>
</tr>
</tbody>
</table>

answered question 105
skipped question 3
Post-termination Evaluation. Table 2.9 shows that eighty-nine participants indicated that they do not conducted post-termination evaluations.

Table 2.9 Post-termination Evaluation

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>15.2%</td>
<td>16</td>
</tr>
<tr>
<td>NO</td>
<td>84.8%</td>
<td>89</td>
</tr>
</tbody>
</table>

Conducting Post-termination Evaluations. Figure 5 shows that the most commonly indicated response to the time frame for conducting post-termination evaluations was one to three weeks after termination (9), followed by one month after termination (3), and “other” (3). The responses labeled in “other” included: not applicable, immediately following termination, and seven days after termination.
Perceptions of Brief Therapy

A Scree Plot of a Principal Components Analysis of the third section of the survey indicates six relevant components, of which accounted for 46.8% of the total variance (refer to table 3.1). The rotated component matrix of the six component loadings is displayed in table 3.2. One question (V73 'Brief assessments are appropriate at determining treatment needs') was excluded from the factor analysis because it loaded consistently on four components and therefore could not be adequately differentiated from the others.
### Table 3.1 Total Variance Explained

<table>
<thead>
<tr>
<th>Component</th>
<th>Initial Eigenvalues</th>
<th>Rotation Sums of Squared Loadings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>% of Variance</td>
</tr>
<tr>
<td>2</td>
<td>3.270</td>
<td>9.909</td>
</tr>
<tr>
<td>3</td>
<td>2.220</td>
<td>6.728</td>
</tr>
<tr>
<td>4</td>
<td>2.090</td>
<td>6.333</td>
</tr>
<tr>
<td>5</td>
<td>1.944</td>
<td>5.891</td>
</tr>
<tr>
<td>6</td>
<td>1.669</td>
<td>5.057</td>
</tr>
<tr>
<td>7</td>
<td>1.527</td>
<td>4.627</td>
</tr>
<tr>
<td>8</td>
<td>1.489</td>
<td>4.511</td>
</tr>
<tr>
<td>9</td>
<td>1.414</td>
<td>4.286</td>
</tr>
<tr>
<td>10</td>
<td>1.277</td>
<td>3.871</td>
</tr>
<tr>
<td>Component</td>
<td>Mean Rating</td>
<td>S.D. Rating</td>
</tr>
<tr>
<td>----------------------</td>
<td>-------------</td>
<td>-------------</td>
</tr>
<tr>
<td>V62 Urgency</td>
<td>2.59</td>
<td>.968</td>
</tr>
<tr>
<td>V63 Speed</td>
<td>3.35</td>
<td>.852</td>
</tr>
<tr>
<td>V64 Signi</td>
<td>2.83</td>
<td>.852</td>
</tr>
<tr>
<td>V65 focus</td>
<td>2.12</td>
<td>.760</td>
</tr>
<tr>
<td>V66 separ</td>
<td>2.90</td>
<td>.938</td>
</tr>
<tr>
<td>V68 attain</td>
<td>3.41</td>
<td>.888</td>
</tr>
<tr>
<td>V71 Confirm</td>
<td>2.78</td>
<td>.917</td>
</tr>
<tr>
<td>V74 Short</td>
<td>2.98</td>
<td>.875</td>
</tr>
<tr>
<td>V75 Goals</td>
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<tr>
<td>V76 Pref</td>
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<td>V78 Address</td>
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<td>V79 Drive</td>
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<tr>
<td>V82 Setting</td>
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<td>V83 Trust</td>
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<td>V84 First</td>
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<td>V87 Single</td>
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<td>V89 Model</td>
<td>2.23</td>
<td>.821</td>
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<tr>
<td>V90 Intervention</td>
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<tr>
<td>V91 Promote</td>
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<td>.638</td>
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<td>V92 Universal</td>
<td>2.44</td>
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<tr>
<td>V93 Future</td>
<td>2.51</td>
<td>.946</td>
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<tr>
<td>V94 Music</td>
<td>3.10</td>
<td>.764</td>
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<tr>
<td>V95 Life</td>
<td>1.76</td>
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<tr>
<td>V67 rel R</td>
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<td>.788</td>
</tr>
<tr>
<td>V69 Speed R</td>
<td>3.34</td>
<td>.864</td>
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<td>V70 Effect R</td>
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</tr>
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<td>V72 Cat R</td>
<td>2.61</td>
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<td>V77 High R</td>
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<td>V80 Long R</td>
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<td>V81 Mutual R</td>
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<td>V85 Post R</td>
<td>2.77</td>
<td>.806</td>
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<td>V86 Closure R</td>
<td>2.15</td>
<td>.848</td>
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<tr>
<td>V88 Work R</td>
<td>2.79</td>
<td>.952</td>
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</table>

Extraction Method: Principal Component Analysis.
Rotation Method: Varimax with Kaiser Normalization.
Table 3.2 displays the six relevant components. Each of the components, listed from highest to lowest, consisted of absolute loading values of .500 or higher.

**Table 3.2 Component Loadings**

<table>
<thead>
<tr>
<th>Component 1: Value of brief music therapy given trends and constraints in the field</th>
<th>Loading</th>
</tr>
</thead>
<tbody>
<tr>
<td>V92 A universal brief music therapy model will establish more opportunities for music therapy</td>
<td>.751</td>
</tr>
<tr>
<td>V89 A brief therapy model is needed in music therapy</td>
<td>.703</td>
</tr>
<tr>
<td>V93 Brief therapy work is going to be more necessary in the future of the music therapy profession</td>
<td>.621</td>
</tr>
<tr>
<td>V91 A brief therapy model will promote music therapy's interests in short-term settings</td>
<td>.587</td>
</tr>
<tr>
<td>V66 Therapeutic goals are inseparably tied to time-limitations</td>
<td>.563</td>
</tr>
<tr>
<td>V78 Brief assessments could be effective at addressing group collective needs</td>
<td>.521</td>
</tr>
</tbody>
</table>

**Component 2: Effectiveness of the length of brief music therapy for clients of different levels of functioning**

| V77 Brief therapy is only effective with higher functioning clients | .699 |
| V95 Brief therapy can make a difference in a client's life | .686 |
| V87 Brief therapy is effective in a single session | .622 |
| V74 Short-term work is equally effective as long-term therapy | .521 |

**Component 3: Significance and impact of time-limitations in brief music therapy**

| V68 Time-limitations speed up the process of goal attainment | .699 |
| V63 Time-limitations in therapy increase the speed at which therapeutic goals are attained | .563 |
| V67 Time-limitations are irrelevant in | .549 |
developing a sense of urgency in the therapeutic process

**V64** Time-limitations in therapy increase the significance of termination within the context of the therapeutic process

**V62** Time-limitations in therapy create a sense of urgency within the therapeutic process

Component 4: Effectiveness of brief music therapy with respect to specific stages of the therapy process

**V81** Brief therapy is only effective when there is a mutual contract made between therapist and client

**V70** Time-limitations do not affect treatment development

**V71** Brief assessments can be equally confirmative to extended assessments

Component 5: Significance of termination/closure

**V88** Termination is not necessary when working in a single session

**V80** Termination in brief therapy is less significant than in long-term therapy

**V86** Providing closure is not necessary in short-term work

Component 6: Significance of assessment/evaluation

**V72** Brief assessments are categorically less flawed than extended assessments

**V85** Post-termination evaluations are inappropriate in short-term work
Component Descriptions

Component 1. Component 1 "Value of brief music therapy given trends and constraints in the field" was derived from three key factors trends, value, and constraints. The highest loadings seemed to be directed towards the themes of trends and value (.751, .703, .621, .587). However, constraints on therapeutic time were relevant in addition to brief music therapy being effective at addressing group needs.

Component 2. Component 2 "Effectiveness of the length of brief music therapy for clients of different levels of functioning" was derived from three key factors effectiveness, length of treatment, and levels of functioning. The highest loadings focused on effectiveness and levels of functioning (.699, .689, .622). The highest loading was indicated on "Brief therapy is only effective with higher functioning clients." Length of treatment was a major theme found signifying an interest in the future to compare the effectiveness of both short-term (including single-sessions) with long-term treatment models.

Component 3. Component 3 "Significance and impact of time-limitation in brief music therapy" was derived from three key factors significance, impact, and time-
Considerations in Brief Therapy 61

limitations. Each variable focused on the nature of time-limitations in therapy and the impact to which time has on goals, the therapeutic process, and termination. The highest loading (.699) addressed “time-limitations speed up the process of goal attainment” while the lowest loading (.516) focused on “time-limitations in therapy create a sense of urgency within the therapeutic process.”

Component 4. Component 4 “effectiveness of brief music therapy with respect to specific stages of the therapy process” had a statistical tendency to pull towards the disagree/strongly disagree poll. The two key factors noted in component 4 were effectiveness and stages of therapy. The majority of those who responded to V70R “Time-limitations do not effect treatment development” (Mean 2.24) and V81R “Brief therapy is only effective when there is a mutual contract made between therapist and client” (Mean 3.15) tended to disagree/strongly disagree with those statements.

Component 5. Component 5 “Significance of termination/closure” was derived from three key factors termination and closure. The components with the high loadings (.823, .673, .586) point to termination and
Considerations in Brief Therapy 62

closure not being as essential to clinicians when working in single-session or short-term therapy.

Component 6. Component 6 "significance of assessment/evaluations" derived from two key factors assessments and evaluations. The highest loading V72R "Brief assessments are categorically less flawed than extended assessments" (-.635) suggested a strong disagreement towards the statement. Additionally, there was a strong agreement (.600) towards V85R.

Discussion

Overall, this study was an exploratory look into brief music therapy in clinical settings throughout the United States. The purpose of the study was to ascertain the extent to which music therapists are working in ways that utilize components of brief therapy.

A total of 108 (10% of those invited) registered music therapists responded to the survey. Gender seemed to stand out in the findings. The majority of participants 92.5% were female between the ages of 22 to 39 years (n=87). Several aspects of the data adhered to some of the trend consistencies in the music therapy field (AMTA, 2010) such as: 1) the majority had two to five years of experience, 2)
the largest pool of music therapists were from the Mid-
Atlantic region, 3) the majority held a bachelor’s degree,
and 4) the majority worked both with groups and with
individuals.

In terms of different settings, psychiatry (including
forensic) was one of the more common places of employment
for short-term work, which in part supported by a recent
Delphi Poll study (Cassity, 2007). Private practice was
also fairly common place of employment, which may imply a
possible trend in the expansion of short-term private
practices, perhaps due to shifts in reimbursement rights
(Cassity & Cassity, 2006). Roughly one-third of those who
responded indicated that their place of employment admits
clients for greater than one week but less than or equal to
3 months of care. Only 10% of participants who responded to
this question indicated that they clients for less than one
week of care.

Interestingly, although Neurological Music Therapy
(NMT) was the training designation indicated as most
commonly held, the treatment areas most notably related to
NMT work (cognitive/neurological and fine/gross motor) were
rated as less significant than the area of
interpersonal/socialization. Additionally, neurological
work was most commonly linked with “expression” as a client need. A possible explanation maybe, as Shultis (1999) suggests, that conditions in short-term hospitalization makes forms of self-expression difficult for clients (regardless of primary diagnosis or reason for admission).

There were two main questions posed in the study. There were: 1) Are music therapists utilizing brief therapy? 2) What are music therapists’ perception(s) of brief therapy?

**Research Question One: Are Music Therapists Utilizing Brief Therapy?**

According to the findings of this study, music therapists are indeed utilizing elements of brief therapy in short-term settings. Two-thirds of participants noted that they work with clients in single-sessions treatments, which supports that music therapists are working in brief treatment applications with different populations. Interestingly, one-third specified that their clinical population is directed by a limited set number of sessions, yet one-third stated that the number of sessions is clinically determined in other words, based on the client need(s). This information does adhere to the two clinical time frame models presented in the literature review: 1)
Considerations in Brief Therapy 65

time-limited therapy and 2) clinical determined therapy
(Miller, 1996).

Additional findings that support the first research
question was about treatment collaboration and termination.
Two-thirds of the participants specified that they
collaborate with clients in treatment planning, and that
they discuss clinical expectations with their clients. More
than half specified that they discuss termination with
clients, yet about the same number indicated that they do
not discuss it in the first session. Battino (2007)
suggests that having “expectations” may help diminish the
number of sessions needed, while Reiter (2007) suggests
that clinical expectations are important for effective
brief therapy work. Ideally, termination should be solely
up to the client (Stern, 1993) who should be given an
appropriate amount of time to process closure (McGuire &
Smeltekop, 1994b). On the contrary, limitations placed on
acute-care settings put emphases on the separation process
(McGuire & Smeltekop). Interestingly, based on the core
definition of brief therapy, post-termination evaluations
and referrals are important; yet, few participants
indicated that they offer these components into their
practice.
Research Question Two: What are Music Therapists’ Perceptions of Brief Therapy?

Of the thirty-four brief music therapy statements generated, several statistically grouped well into six components. The six components helped to formalize some clinically relevant perceptions of brief therapy within the music therapy profession.

Component 1, “Value of brief music therapy given trends and constraints in the field” validates the need for brief music therapy, given the cost progression of healthcare, as well as general need to explore possible short-term treatment models. Pearson (2005) supports this by arguing the need for more definitive brief therapy approaches in acute care as it applies to music therapy practices. Component 2, “Effectiveness of the length of brief music therapy for clients of different levels of functioning” emphasizes the need for further examination of the effectiveness of brief music therapy with different populations and needs. Though the highest loading in Component 2 indicated that “Brief therapy is only effective with higher functioning clients,” Murphy (1992) suggests that brief therapy can serve many populations, as long as there is an appropriate level of structure and direction
given. Component 3, "Significance and impact of time-limitations in brief music therapy" suggests that music therapists are interested in exploring the significance and possible impact of "time limitations" on the therapeutic process. Time limitations play a critical role during treatment in acute care; hence, there is support for exploring the meaningfulness and impact of brief music therapy on clients in time-limited settings (Cepeda & Devenport, 2006; Jacbowitz, 1992; Murphy, 1992).

Component 4, "Effectiveness of brief music therapy with respect to specific stages of the therapy process" validates the need to study brief music therapy with respect to the stages, rather phases, of treatment. There is little information pertaining to the effectiveness of brief music therapy; however, there is support that brief therapy is only effective as the underlying strength of the mutual contract (Bolter et al., 1990; Ingram, 2003; Weiss & Marmer, 1993). Component 5, "Significance of termination/closure" highlighted that termination and closure may not be as significant in the process of short-term work as it may be in long-term settings. There seems to be a disconnect between the literature and actual practice with regards to termination and closure. The
literature suggests termination should be given adequate time (McGuire & Smeltekop, 1994a), yet the finding supports Jacobowitz’s (1992) view that every client encounter be viewed as a possible termination session. Component 6, "Significance of assessment/evaluation" expressed the need to examine brief assessment and the need for post-termination evaluations further in music therapy clinical and research work. Though the literature notes assessment tools for short-term settings (Cassity & Cassity, 2006), there is greater need for an updated assessment model to meet the needs of music therapists working in time-limited practices.

Implication for Clinical Work

Music can be considered, “a time-based link to reality” (Shultis, 1999). It is ironic to think that constraints on time are being imposed on music therapy, while the very nature of music therapy clinical work places so much emphasis on “space” and “time” within the therapeutic context (Sears, 2007). Considering the limited nature of this study, the present findings show that music therapists are adapting their clinical work to short-term settings. Thus, there needs to be more awareness among clinicians concerning the effectiveness and limitations of
brief music therapy. Brief music therapy can drastically reach those who can use the unique services of music therapy in acute settings. There is significant research into the effectiveness of single sessions music therapy; hence, there needs to be more emphasis at transferring evidence into clinical settings across various populations.

**Methodological Issues**

There were a number of limitations in this study, methodologically. The key limitations of this study concerns the overall validity of the survey, and the accompanying matter of controlling for researcher bias. However, the survey was reviewed by fellow graduate student peers and professionals in order to assure impartiality, and to assure clarity and readability. Still, there may have been weaknesses in the validity of the responses obtained based on the readability of any of the given questions or rating statements.

Because most questions were "closed" in construction, participants were not given many opportunities to express their own thoughts and ideas about brief music therapy via open-ended description, which may have represented a limiting factor. In addition, the CBMT registry only differentiated professionals based on populations, and does
not group therapists between short-term and long-term care, which may have impacted sample selection.

In terms of external validity, the sample size was small, and thus the results reflect only a particular sample, not necessarily generalizable among the music therapy profession as a whole. However, findings may still address future clinical work in music therapy in meaningful ways.

**Implications for Future Research**

There have been several attempts in examining brief approaches in music therapy (as cited in the literature review), yet there still is no general brief music therapy model. This study was not an attempt to create a model, but rather an exploration of brief therapy work and perceptions of this work in music therapy. It is hoped that these findings can help prompt future research, and in related areas, as part of creating a model. As a part of this, a more thorough exploration of the effectiveness of brief music therapy approaches is needed with specific populations, and with greater sample sizes.

In addition, there is a need for more research exploring the effectiveness of single-session designs, and
which examine client qualitative benefits of brief music therapy. Brief therapy can be a possible benefit in the fast growing research area of “dose response” measurements in music therapy since time, urgency, and goal durations are major factors in such work (Silverman & Marcionetti, 2004; Vink & Bruinama, 2003). Because the study did not address whether music therapists are utilizing any of the models presented in the literature review, future studies may also consider exploring whether music therapists are utilizing such brief therapy and/or brief music therapy models.

Since Component 5, “Significance of termination/closure” revealed a disconnect from the literature and actual practice, further study is needed to explore the individual interpretations of both termination and closure contextually. Additionally, this study could benefit from follow-up qualitative interviews with working music therapists in short-term settings; hence, to gain further sight into the kinds of perceptions about brief therapy revealed in this study.

Personal Statement from the Researcher

The following is a statement concerning my (the researcher’s) experience conducting academic research for
the first time. The thesis process was one of the most
difficult yet rewarding tasks I have ever undertaken.
Writing was never one of my strong points so I was
stressed, as I assume most are, with the thesis process
from the beginning. I have grown more appreciative of
research and all the dedication and time that goes into it.
I have taken an interest in exploring brief music therapy
because it seemed relevant for the future of the music
therapy profession. Music therapy is going to be more
needed as healthcare continues to evolve and will be a
vital application in acute-care practices.

Conclusion

This study explored the extent to which music
therapists are working in ways that utilize components of
brief therapy. Findings revealed that music therapists who
work in acute-care environments have in fact adapted
components of brief therapy in their practices. The study
was an exploratory look into the nature of brief therapy as
it relates to music therapy clinical work and may represent
a first step in developing a general model that can help
guide brief music therapy practice in the future.
References


Considerations in Brief Therapy


at the Second Annual American Music Therapy Association Conference, St. Louis, MO.


recreation group therapy in acute-care. Paper presentation at the 31st Annual Canadian Association for Music Therapy Conference, Winnipeg, Manitoba.


http://www.psychiatrictimes.com/display/article/10168/50741

Silverman, M. J. (2009). The effect of single-session psychoeducational music therapy on verbalization and
perceptions in psychiatric patients. *Journal of Music Therapy, 46*(2), 105-131.


Appendix A - Cover Letter

MONTCLAIR STATE UNIVERSITY
INSTITUTIONAL REVIEW BOARD

Cover Letter

Dear Colleagues,

I am a Master's student in the music therapy program at Montclair State University doing a thesis entitled:
“Considerations in a Brief Therapy Model in Music Therapy.” As part of my thesis I am conducting a survey to ascertain the extent to which music therapists are working in ways that utilize components of brief therapy. Brief therapy can be generally defined as an eclectic clinical approach that addresses client needs within a predetermined or clinically determined time-frame. I am very interested in determining if music therapists are utilizing brief therapy and to understand their perceptions of brief therapy work. Benefits for this study will help raise awareness about brief therapy in music therapy.

You are listed in the Certification Board for Music Therapist, Inc. (CBMT) registry as a certified practicing music therapist and I am writing to ask if you would take part in this study. The survey will take approximately fifteen minutes to complete. Your identity will remain completely anonymous (including to the researcher), and data will be presented in aggregate form only. You are under no obligation to answer any questions. You may choose not to participate or withdraw from the study at any time without repercussions.

Below are five bullet statements. If your clinical work reflects 3 or more of these bullet statements please continue to the survey by clicking the link below. If not, please do not continue but thank you for considering participating in this study.

- My clinical work is subject to time limitations
- My clinical work involves a limited number of sessions
- I generate goals in consideration of time limitations
- A major focus of my work is addressing immediate needs or conditions of clients
- My clinical work involves a clinical contract or other type of working agreement between the client and therapist
Appendix A - Continued

MONTCLAIR STATE UNIVERSITY
INSTITUTIONAL REVIEW BOARD

If you have any questions or would like results of the survey you are welcome to contact me by email at francisj2@mail.montclair.edu. For questions about participant’s rights one can refer to Debra Zellner, IRB Chairperson, at (973) 655-7583 or reviewboard@mail.montclair.edu. After completion this thesis will also be available through the MSU Library.

Thank you for your participation!
Respectfully,
Justin Francis

(Link to Survey Monkey will be placed here)

The act of submitting the survey indicates your consent to have your data used for the study.
### Appendix B - Survey

#### Survey of Brief Therapy in Music Therapy

**1. BACKGROUND INFORMATION**

1. **Gender:**
   - [ ] Male
   - [ ] Female

2. **Age:**
   - [ ] Under 22
   - [ ] 22-29
   - [ ] 30-39
   - [ ] 40-49
   - [ ] 50-59
   - [ ] 60+

3. **Years of experience as a music therapist:**
   - [ ] ≤ 1 yr
   - [ ] 2-5 yrs
   - [ ] 6-10 yrs
   - [ ] 11-15 yrs
   - [ ] 16-20 yrs
   - [ ] 20+

4. **Region in which you work:**
   - [ ] Great Lakes
   - [ ] Southeastern
   - [ ] Mid-Atlantic
   - [ ] Southwestern
   - [ ] Midwestern
   - [ ] Western
   - [ ] New England

5. **Highest degree earned:**
   - [ ] Bachelors
   - [ ] Masters
   - [ ] Doctorate

6. **Additional training designations held:**
   - [ ] FAMI
   - [ ] NICU-MT
   - [ ] AMT
   - [ ] HPMT
   - [ ] NRMT
   - [ ] NMT
### Survey of Brief Therapy in Music Therapy

7. Type of facility where currently employed (Select only one of any jobs you hold that meets the five bullet criterion presented in the cover letter):

- [ ] Psychiatric Care Center
- [ ] Physical Rehabilitation Center
- [ ] General Medical Care Center
- [ ] Drug/Alcohol Rehabilitation Center
- [ ] Cancer Center
- [ ] Pediatric Care Center
- [ ] Private Practice
- [ ] School/Developmental Center
- [ ] Other (please specify)

8. How long have you been employed at current job?

- [ ] ≤ 1 yr
- [ ] 2-5 yrs
- [ ] 6-10 yrs
- [ ] 11-15 yrs
- [ ] 16-20 yrs
- [ ] 20+

9. How long do clients typically receive care at your facility?

- [ ] Less than or equal to one week of care
- [ ] Greater than one week but less than or equal to three months of care
- [ ] Greater than three months of care

10. Employment title:

   - [ ]

11. In your work, do you provide?

- [ ] Group Sessions
- [ ] Individual Sessions
- [ ] Both
### Survey of Brief Therapy in Music Therapy

12. Please place treatment needs in your work according to order of importance (6 being most important and 1 being least important):

<table>
<thead>
<tr>
<th></th>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
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<td>Interpersonal/Socialization</td>
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<tr>
<td>Affective/Behavioral</td>
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<tr>
<td>Sensory/Imagery</td>
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<tr>
<td>Cognitive/Neurological</td>
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<tr>
<td>Speech/Language</td>
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<tr>
<td>Fine/Gross Motor</td>
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</tbody>
</table>

13. Identify client need(s) you most commonly encounter in your work (Select all that apply):

- [ ] anxiety
- [ ] Sleep disturbances
- [ ] Reality orientation
- [ ] Relaxation
- [ ] Expression
- [ ] Recovery
- [ ] Hospital experience
- [ ] Psychosocial
- [ ] Problem solving
- [ ] Coping
- [ ] Education
- [ ] Family/Friends
- [ ] Pain
- [ ] Leisure-time skills
- [ ] Comfort/Palliative
### Survey of Brief Therapy in Music Therapy

#### 2. YES/NO QUESTIONS

1. Are you limited to a specific number of sessions per client?
   - [ ]
   - If YES, what is the typical number of sessions given?

2. Do you decide on the number of sessions given per client?
   - [ ]
   - If YES, what is the typical number of sessions given?

3. Do you ever work with clients in a single session?
   - [ ]

4. Do you collaborate with clients in treatment planning?
   - [ ]

5. Do you discuss clinical expectations with clients?
   - [ ]

6. Do you discuss termination with clients?
   - [ ]

7. If YES to question 6, do you discuss termination with clients during the first session?
   - [ ]

8. If NO to question 7, at what point do you discuss termination?
   - [ ]

9. Do you provide referrals upon termination?
   - [ ]

10. Do you conduct post-termination evaluations?
    - [ ]

11. If YES to question 10, how long after termination do you conduct these evaluations?
    - [ ]
# Survey of Brief Therapy in Music Therapy

## 3. AGREE/DISAGREE STATEMENTS

In the following questions indicate to which range do you agree or disagree to the following statements.

### 1. Please indicate your responses below

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither Agree or Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
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<tr>
<td>Brief assessments can be equally confirmative to extended assessments</td>
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<td></td>
<td></td>
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<td>Termination should be discussed during the very first session</td>
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<td>Brief therapy work will increase the effectiveness of music therapy</td>
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<tr>
<td>Brief therapy is only effective with higher functioning clients</td>
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<tr>
<td>Termination drives brief therapy work</td>
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<tr>
<td>Brief assessments could be effective at addressing group collective needs</td>
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<td>Post-termination evaluations are inappropriate in short-term work</td>
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<td>Brief assessments are categorically less flawed than extended assessments</td>
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<td>Providing closure is not necessary in short-term work</td>
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<td>Time limitations in therapy increase the significance of termination within the context of the therapeutic process</td>
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<td>Termination is not necessary when working is a single session</td>
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Music therapy is effective in brief interventions.

Brief therapy is only effective when there is a mutual contact made between therapist and client.

Termination in brief therapy is less significant than in long-term therapy.

Time limitations do not effect treatment development.

Short-term work is equally effective as long-term therapy.

Brief therapy is effective in a single session.

Time limitations in therapy force therapy to focus on here-and-now issues.

A mutual contract aids in establishing trust between client-therapist over the therapeutic process.

Brief assessments are appropriate at determining treatment needs.

Therapeutic goals are inseparably tied to time limitations.

Brief therapy goals should focus on reducing symptomatology.

Brief therapy can make a difference in a client's life.

Time limitations in therapy create a sense of urgency within the therapeutic process.

Time limitations speed up the process of goal attainment.

In short-term settings every session should be viewed as a possible termination session.

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<th>Survey of Brief Therapy in Music Therapy</th>
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## Survey of Brief Therapy in Music Therapy

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<th>Brief assessments should focus on determining musical functioning and preferences</th>
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<td>Time limitations are irrelevant in developing a sense of urgency in the therapeutic process</td>
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<td>A brief therapy model is needed in music therapy</td>
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<td>Time limitations in therapy increase the speed at which therapeutic goals are attained</td>
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<td>A universal brief music therapy model will establish more opportunities for music therapists</td>
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<td>Brief therapy work is going to be more necessary in the future of the music therapy profession</td>
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Appendix C - IRB Approval

April 27, 2010

Mr. Justin Francis
8 Decker Road
Flemington, NJ 08822

Re: IRB Number #: 000888
Project Title: Considerations in a Brief Therapy Model in Music Therapy

Dear Mr. Francis:

After an exempt 2 review, Montclair State University’s Institutional Review Board (IRB) approved this study’s amendment on April 23, 2010.

Before requesting amendments, extensions, or project closure, please reference MSU’s IRB website and download the current forms.

Should you wish to make changes to the IRB-approved procedures, prior to the expiration of your approval, submit your requests using the Amendment form.

For Continuing Review, it is advised that you submit your form 60 days before the month of the expiration date above. If you have not received MSU’s IRB approval by your study’s expiration date, ALL research activities must STOP, including data analysis. If your research continues without MSU’s IRB approval, you will be in violation of Federal and other regulations.

After your study is completed, submit your Project Completion form.

If you have any questions regarding the IRB requirements, please contact me at [973-655-4327, reviewboard@mail.montclair.edu] or the Institutional Review Board.

Sincerely yours,

Dr. Debra Zellner
Interim IRB Chair

cc: Dr. Brian Abrams, Faculty Sponsor
    Ms. Amy Aiello, Graduate School